Request for Payment of Medical Expenses for Insured Person or Dependent

[for therapeutic devices, therapeutic eye glasses, etc.]

Information on insured person

Insurance card code and number	Code: ●● / Number: XXXX	Name of affiliated office/department	XXXX Co., Ltd., XXXX Branch Telephone number (ext.) 03-1234-5678(999)
Name	Furigana ケンポ タロウ Taro Kempo	Date of birth	●● (Y) ●● (M) ●● (D)
Address, telephone number, etc. of applicant (daytime phone number)	〒123-4567 XXXX Condominium, #456 1-2-3 XXXX-cho, XXXX Ward, Tokyo Telephone number 03-7891-2345		
Employee ID number	1234567	E-mail address	XXXX@XXXX.ne.jp

Application details

Person undergoing medical treatment (circle the applicable person)	Insured person / Family member (dependent)	Name of person undergoing medical treatment	Hanako Kempo
Name of injury / illness	Fracture of upper right humerus	Date of birth of person undergoing medical treatment	●● (Y) ●● (M) ●● (D)
Cause and progress of symptoms	Fell down stairs at home and fractured humerus	Date of injury or onset of illness	●● (Y) ●● (M) ●● (D)
Name of medical institution where examination was conducted	XXXX Hospital	Address of medical institution where examination was conducted	X-X-X-cho, XXXX City, Fukuoka Prefecture
Period during which medical treatment was conducted	From ● (Y) ● (M) ● (D) to ● (Y) ● (M) ● (D) ● days	If hospitalized during the period listed on the left, the period of that hospitalization	From (Y) (M) (D) to (Y) (M) (D) days
Cost of therapeutic devices, etc.	28,000 yen	Date of attaching therapeutic devices, etc.	● (Y) ● (M) ● (D)
Content of treatment	1. Wearing of therapeutic devices, etc. 2. Creation of therapeutic eye glasses, etc. 3. Other ( )		
Was the need for medical care caused by a third party (traffic accident, etc.)?	No / Yes	If the need for medical care was caused by a third party, please describe the situation	

*If you wish to delegate receipt, please complete the authorization letter.

Authorization Letter

☑(1) I hereby entrust the receipt of benefits based on this claim to the employer. ← Insert a check (☑) in the box of the applicable item.

☐(2) I hereby entrust the receipt of benefits based on this claim to the representative listed below. Date: ● (Y) ●● (M) ●● (D)

Insured person (applicant)	Name	Taro Kempo
Representative (individual actuall		

Information on transfer

Name of financial institution		ch number	
Type of accoun			

Please fill in the section for the authorization letter, except for persons enrolled in voluntary and continuous health insurance coverage and retirees.

If you are a person enrolled in voluntary and continuous health insurance coverage or a retiree, please fill in the section for information on transfer destination.

■ Documents for Attach

[For Therapeutic Devices]

1. Physician's certificate, instructions, or written diagnosis (original copy)
2. Receipt (original copy)
3. Written document confirming wearing of the device (photograph of the created device)

[For Therapeutic Eye Glasses, etc.]

1. Physician's written instructions for creation of therapeutic eye glasses, etc.
2. Patient examination/test results
3. Receipt (original copy)

Remarks

Individual number (not required when entering the code and number from the insured person's card)	
*If you entered your Individual number, please attach the following documents to confirm your Individual number and identity. One of the following: (1) Copy of Individual number notification card, (2) Copy of certificate of residence listing Individual number, (3) Copy of Individual number card (both sides) ・When attaching (1) or (2) above, also attach one of the following: copy of driver's license or copy of passport	

Date request received (stamp)

Works Human Intelligence Health Insurance Society

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